COMMUNITY HEALTH

MEDICAL • DENTAL • BEHAVIORAL HEALTH

MEDICAL RECORDS
71 Allen Street, Suite 402, Rutland, VT 05701
Phone 802-671-5800 | Fax 802-772-7973
CHCRR.org

Authorization For Release of Behavioral Health Records

NAME (print):_____ DOB: _____

FORMER NAME: _____ PHONE: _____

ADDRESS: _____ CITY/STATE: _____

SPECIFY INFORMATION TO BE RELEASED:

- ☐ Psychiatric Evaluations
- ☐ Psychological Evaluations
- ☐ Treatment Plans
- ☐ Diagnosis
- ☐ Neurological
- ☐ Psychological Testing Reports
- ☐ School Disciplinary Reports
- ☐ Adaptive Evaluations
- ☐ Educational Reports (i.e. IEP, ER)
- ☐ Behavioral Management Plans (Disciplinary Reports)
- ☐ Transfer/Discharge Summaries
- ☐ Attendance Records
- ☐ Other (Please specify)
- ☐ **Complete Behavioral Health Record**
  Date Range: __/__/__ to __/__/__

FORM OF DISCLOSURE: ☐ Written ☐ Verbal

METHOD OF DELIVERY: ☐ U.S. Mail ☐ Fax ☐ USB Drive ☐ Patient Pick-Up at Medical Records

FEES: If paper records are released to the patient fee is $0.50 per page or $5 minimum; a USB is $10 (18 V.S.A. §9419)

☐ **Information REQUESTED FROM:**

DOCTOR/FACILITY: _____

ADDRESS: _____ PHONE/FAX: _____

SPECIFIC PURPOSE OF TOPICS CHECKED:

- ☐ Coordination of Educational Services
- ☐ Referral to External Agency/Provider
- ☐ Coordination of Treatment/Services
- ☐ Insurance/Social Security Benefits
- ☐ External Agency/Provider
- ☐ Transfer of Care
- ☐ Other_____

☐ **Information RELEASED TO:**

☐ Community Health Medical Records, 71 Allen St, Suite 402, Rutland, VT 05701, P: 802-671-5800/F: 802-772-7973

☐ Other: _____

Address: _____ Phone/Fax: _____

I request the above information be released. I understand that information released in my medical record may include information on drug and alcohol abuse, psychiatric impairments, AIDS/HIV related illnesses or genetic testing. I understand that I have the right to restrict this information should I choose. I understand that federal regulations (42 CFR part 2) prohibit the re-disclosure of drug and alcohol treatment infmmation without my written consent or as allowed by the regulations. I understand that under VT statute, my health information can only be disclosed with my authorization or as mandated by an express provision of law. For disclosures made to organizations outside of the State of VT, all other health information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA.

I understand this authorization is voluntary and can be revoked in writing at any time. A revocation must be submitted in writing to the address above. Revocation will not be effective for the disclosure of healthcare information previously authorized to be released.

Authorization to release this information is valid for 12 months from the date of signature on this release. A photocopy or facsimile of this authorization is as valid as the original.

NOTE: Once information has been disclosed, can no longer protect it from Community Health further disclosure.

Print Name and Check Relationship:	Signature	Date
☐ Self/☐ Parent/☐ Guardian/☐ Loco Parentis		

Processing time for a request is usually within 7 to 10 business days after the medical request is received